STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE

INITIAL STATEMENT OF REASONS

PROPOSED AMENDMENTS TO THE FAIR CLAIMS SETTLEMENT PRACTICES REGULATIONS PURSUANT TO INSURANCE CODE SECTION 790.10

INTRODUCTION

Pursuant to California Insurance Code Section 790.10, California Insurance Commissioner John Garamendi ("Commissioner") proposes amendments to California Code of Regulations, Title 10, Chapter 5, Subchapter 7.5, entitled "Fair Claims Settlement Practices Regulations". The original regulations, effective January 13, 1993, were promulgated to provide definitive standards of conduct to insurers and other licensees for compliance with the Insurance Code's unfair claims settlement practices statute, Section 790.03(h). These regulations were first amended effective May of 1997. Although further amendments were proposed and scheduled to become effective on July 23, 2003, Los Angeles County Superior Court Judge Peter Lichtman enjoined implementation of the proposed regulations in response to a lawsuit brought by insurer trade groups. On June 7, 2004, the parties entered into a partial settlement that resulted in many of the proposed regulations becoming implemented, effective October 4, 2004. The partial settlement also contemplated the publication for public comment of additional proposed regulations which led to this submittal.

SPECIFIC PURPOSE AND REASONABLE NECESSITY OF REGULATION

The specific purpose of each adoption, amendment, or repeal and the rationale for the Commissioner's determination that each adoption, amendment or repeal is reasonably necessary to carry out the purpose for which it is proposed is set forth below.

SECTION 2695.1. Preamble.

Section 2695.1(b) **Amend**

Existing subsection 2695.1(b) sets forth the authority under which these regulations are promulgated and the intended scope of these regulations by providing that other acts not specifically delineated in these regulations may also violate California Insurance Code Section 790.03(h).

For clarification purposes, the subsection has been amended to delete the words "pursuant to the provisions of California Insurance Code Section" and to add the word "or". Amendments were also made to reiterate the fact that the regulations apply to all claims subject to Section 790 et seq. of the California Insurance Code (the "Unfair Practices Act").

Section 2695.1(c) **Repeal/Adopt**

In recognition of the unique tripartite relationship between the surety, beneficiary and principal, the existing subsection specifies that only some of the claims regulations apply to the handling or settling of claims brought under surety bonds. The proposed change to this subsection is to repeal it and

adopt new language that recognizes both the unique three-party relationship and the fact that surety insurers and their claims handling acts and practices are subject to the Unfair Practices Act (Insurance Code Section 790.03) as are all other insurers engaged in the business of insurance in California.

SECTION 2695.2. Definitions

Section 2695.2(s) **Amend**
Existing law defines "proof of claim." This subsection is amended to include evidence or documentation received from sources other than the claimant that reasonably supports the claim. This amendment is necessary because the insurer may have access to information that supports the claim but is not in the claimant's possession. This information should also be considered by the insurer and should not be discounted just because it does not come from the claimant.

SECTION 2695.3. (NO CHANGES)

SECTION 2695.4.Representation of Policy Provisions and Benefits

Section 2695.4(b)
Existing law specifies that no insurer shall conceal benefits or coverages that may apply to the claim presented under a surety bond. The subsection is amended to clarify that the prohibition on concealment includes active misrepresentation as well as passive failure to disclose information relating to the claim. The subsection is also amended to reinforce the requirement under Insurance Code 790.03(h)(15) that insurers not mislead the claimant as to the applicable statute of limitations.

Section 2695.4(c) **Amend**
This subsection is amended to add the word “reasonable.” Unreasonable demands by the insurer should not be grounds for denial of a claim.

SECTION 2695.5. (NO CHANGES)

SECTION 2695.6. (NO CHANGES)

Section 2695.7. Standards for Prompt, Fair and Equitable Settlements.

Section 2695.7(b)(1) **Amend**
The current subsection specifies that an insurer that denies or rejects a first party claim shall do so in writing and provide the bases for such denial or rejection in writing. The proposed language clarifies that an insurer must relay to the claimant the specific statute, if any, relied upon by the insurer to deny or reject the claim. The proposed language stems from Insurance Code Section 790.03(h)(13) which provides that it is an unfair claims practice for an insurer that denies a claim to “fail to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law...”(emphasis added.)

Section 2695.7(g)(7) **Amend**
This section is amended to recognize the differences in claim negotiations depending on whether

or not the claimant is represented by counsel. In determining whether a settlement offer made by an insurer is unreasonably low, the Commissioner may take into account any offer of settlement made by the insurer to a claimant not represented by counsel as well as final offers made to a first-party claimant represented by counsel. In negotiating a settlement with the insurer, an unrepresented claimant may not have the expertise to determine what his or her claim is worth and must rely on the insurer to offer a fair settlement. When the claimant is represented by an attorney, the parties go back and forth on proposed settlement amounts and ultimately arrive upon an amount in settlement.

The section is also amended so that it applies to third parties.

Section 2695.7(r) **Adopt**
This new subsection specifies that insurers shall take reasonable steps to ensure the accuracy of computerized data and statistical methods they use in evaluating and settling claims. The subsection also gives examples of what constitutes "reasonable steps." This subsection was added because consumer complaints and Department examinations of insurers have revealed a lack of documented support for the claims settlement amounts offered or paid to claimants. Existing law requires insurers to offer a fair settlement (CIC 790.03(h)(5))and the proposed language attempts to address issues surrounding the current trend by insurers to use third party vendor services to determine damages. The Department receives scores of consumer complaints per year where the accuracy of the settlement offer is at issue. In many of these cases, the insurer has utilized a commercial data vendor to calculate the settlement amount. In many instances the insurer will respond to the Department with the position that only the vendor can explain the methods used or how the settlement amount was derived and only the vendor should be responsible for any inaccuracies found in their products. The Department recognizes that an insurer may use a myriad of advanced technological resources to assist in the processing of claims. However, an insurer is not relieved of its inherent responsibility to offer fair settlements no matter what resources and information are used to establish damages. This regulation is necessary in order to clarify this responsibility.

Section 2695.8. Additional Standards Applicable to Automobile Insurance.

Section 2695.8(b) **Amend**
Existing law refers to the "adjusting and settling" of first party automobile insurance losses claims. This subsection is amended by striking the words "first party" so that the same total loss valuation standards apply to first and third party claims.

The above amendment is made because the valuation of automobiles should be consistent regardless of whether a first or third party claimant is involved. First, existing law requires insurers to effectuate fair settlements and does not differentiate between first and third party claimants (CIC 790.03(h)(5)). Further, if a third party claimant submitted a claim to his or her own insurer, that insurer must comply with current regulations applicable to first party claimants. If the third party claimant's insurer then subrogated the loss to the at fault party's insurer, the third party insurer would get the same amount that it paid its insured.

Under Moradi-Shalal v Fireman's Fund Insurance Companies (1988) 46 Cal. 3d 287; 758 P.2d 58, a third party claimant is barred from filing suit directly against an alleged "at fault" party's insurer. Further, the Moradi-Shalal decision holds that consumers have no private right of action for violations of the Unfair Claims Practices Act (Insurance Code Section 790.03(h)) and reminds the Department that, as the responsible regulator, it should enforce the Unfair Claims Practices Act on behalf of third party claimants. Expanding the current regulations to include third party claimants supports existing law and the Department's efforts to enforce the law.

Existing law also refers to "adjusting and settling" of automobile total loss claims. As the subsection is being amended to apply to both first and third parties, the words "adjusting and settling" are being changed to "evaluating" thus requiring insurers to use the same data in evaluating a total loss but also acknowledging different obligations of the insurer, as set forth in Moradi-Shalal, in settling first party versus third party claims.

Section 2695.8(b)(1)(A) **Amend**
This subsection is amended to add the words "or if the third party claimant retains the loss vehicle" to coincide with the added reference to third parties in subsection 2695.8(b).

Section 2695.8(b)(2) **Amend**
The current subsection defines "comparable vehicle" and the means for determining the cost of a comparable vehicle. The subsection is amended to specify that "the cost of a comparable automobile is the asking price or actual sale price of that automobile." In the majority of total loss valuations reviewed by the Department, a hypothetical "take price" was used to set the value of the comparable automobile. After extensive investigation, the Department determined that these "take prices" do not accurately reflect the actual price these comparable automobiles sold for in the marketplace. In some cases, the take prices were thousands of dollars below the vehicles' actual sale prices. In most cases, only the prices of vehicles actually sold should be used to value a loss vehicle. If an insurer chooses to use a yet unsold vehicle as a comparable automobile, it must use the ask price of that vehicle.

Section 2695.8(b)(3) **Adopt**
This section is adopted to permit greater use of sold vehicle date from the Department of Motor vehicles (DMV). Current law, subsection 2695.8(b)(2), defines "comparable automobile", specifying that the identification of the comparable automobile shall include the telephone number (including area code) or street address of the seller of the comparable automobile. In the case of private sales data (as compared to vehicles sold by dealers) obtained from the DMV, the DMV does not divulge the telephone number or address of the seller for privacy reasons. Current law thus precludes insurers from using private sales data from DMV because of the lack of phone number or address. The adoption of subsection 2695.8(b)(3) will permit the use of private sales data obtained from the DMV so long as the insurer takes reasonable steps to limit the use of private sales data that may be inaccurately reported to the Department of Motor Vehicles. These reasonable steps are necessary as inaccurately low sales prices reported to the DMV by private parties translates into unreasonably low sales data utilized by the insurer and may lead to unreasonably low settlement offers on total loss automobile claims.

Section 2695.8(b)(6) **Adopt**

This language is added to clarify that, while total loss claims should be valued the same in both first and third party situations, the legal determinations made by the insurer in settling a first versus third party are not the same. The settlement of a third party claim goes into determinations of liability and comparative negligence whereas the settlement of a first party claim focuses on the terms of the contract. The proposed subsection recognizes existing law as to how third party claims are settled before, during and after litigation.

Section 2695.8(e)(2) **Amend**
This subsection is amended in light of the enactment of California Insurance Code Section 758.5(which codifies and expands upon the requirements set forth in current subsection 2695.8(e)). This subsection is also amended to delete the word "direct" as this term is unnecessary in light of the terms "suggest" and "recommend" contained in the subsection. Additionally, the term "direct" may imply "require" which is prohibited under subsection 2695.8(e). (A), (B) and (C) of this subsection is also deleted as this language is now contained in Insurance Code Section 758.5.

Section 2695.8(f) (2) **Amend**
With the enactment of Insurance Code 758.5, the term “regulation” is too narrow in scope. As such, this subsection has been amended to replace the word “regulation” with the word “law”.

Section 2695.8(i) **Amend**
This subsection is amended to clarify that, although an insurer must justify an adjustment to the auto claim on account of betterment or depreciation, the insurer is not precluded from making a deduction for prior or unrelated damage to the loss vehicle.

Section 2695.8(j) **Adopt**
This subsection is added to clarify that, in a first party partial loss auto claim, the expense of labor necessary to repair or replace the damage is not subject to depreciation or betterment unless the insurance contract contains a clear and unambiguous provision permitting the depreciation of the expense of labor.

Section 2695.8(k) **Amend** - Re-lettered from 2695.8(j)
This section is amended to clarify the reasonable standard to be used in payment of towing and storage charges. Most automobile insurance policies issued in California place an affirmative duty upon the insured to protect the automobile from further loss. These policies also confer upon the insurer the duty to reimburse the insured for all reasonable fees incurred in protecting the vehicle. When reasonable fees are incurred in towing the vehicle from the scene of the accident and storing the vehicle, these fees should be paid as a matter of course in all auto insurance claims. Although most insurers do reimburse these fees, a trend has developed to limit or exclude reimbursement of these reasonable fees. The amended language is added to address this unfair trend and set forth the reasonable standard. This subsection is also amended so that third parties are similarly treated while recognizing the differences between first and third party claims.

Section 2695.8(k) **Repeal**
Current subsection 2695.8(k) is deleted and its substance has been moved to proposed section

2695.8(k), above. Also, as written, it does not contemplate situations where the insured is unable to use the insurer identified tow company due to reasons beyond his or her control such as being unconscious from an accident or non-response from the insurer's tow company.

Section 2695.85 (NO CHANGES)

Section 2695.9. Additional Standards Applicable to Fire and
Extended Coverage Type Policies with Replacement Cost Coverage.
Section 2695.9(c)(2) **Amend**
The language in this subsection is amended to clarify that, if the claimant accepts the insurer's suggestion or recommendation for a repair shop, the insurer shall then cause the damaged property to be restored to at least the same condition as before the loss. The subsection, as amended, is consistent with standards set forth in subsection 2695.8(e) for automobile claims.

Section 2695.9(e) **Amend**
The language in this subsection is amended to clarify that the subsection is not intended to preclude legal proceedings or procedures outside the appraisal process such as declaratory relief actions on coverage issues.

Section 2695.9(f) **Adopt**
This subsection is added because depreciation, betterment and salvage calculations are not limited to the handling of auto claims but are also prevalent in the adjustment of other property loss claims (such as homeowners'). The minimum standards set forth for automobile claims should apply to all property losses.

Insurance Code Section 2051 sets out the measure of recovery on property losses as being "the amount it would cost the insured to repair, rebuild, or replace the thing lost or injured less a fair and reasonable deduction for physical depreciation…" This subsection is designed to clarify what is meant by physical depreciation and how physical depreciation is deducted from a claim.

Section 2695.9(f) (1) **Adopt**
This newly adopted subsection specifies that "the cost of labor is not subject to depreciation." Under Insurance Code Section 2071, "Company's Options", an insurer may opt to repair, rebuild or replace the damaged property with that of like kind and quality. In exercising this option, the insurer must calculate the amount it would cost to repair, rebuild or replace as set forth in Insurance Code Section 2051. Under Insurance Code Section 2051, the insurer is obligated to pay the full expense of repairing, rebuilding or replacing the damaged property "less a fair and reasonable deduction for physical depreciation." Some insurers take the position that the cost of labor is depreciable, which has resulted in consumers being paid less than a fair and reasonable amount to repair or rebuild the damaged property. This leaves the insured with significant out-of-pocket expenses not contemplated or expected. The Department has taken the position that the expense of labor is not depreciable as only the physical property can be depreciated. The language of this new subsection is necessary in order to interpret the term "physical depreciation" and to clarify that depreciation of labor is not a component of physical depreciation.

In addition, Insurance Code Section 2051 defines actual cash value, for total losses, as the fair market value of the property. As labor is a function not a physical item, the fair market value of labor can only be determined in today's dollars and is, therefore, not subject to depreciation.

Section 2695.10. Standards Applicable to Surety Insurance.

Section 2695.10(a) **Amend**
This subsection is amended to clarify that surety insurers may not discriminate in the handling of a claim based on the age of the claimant.

Section 2695.10(b) **Amend**
This subsection is amended to reduce the time to accept or deny a surety claim from 60 days to 40 days and also requires surety insurers to provide a written explanation for the denial or rejection of a claim. Although surety insurance is different in that it involves three parties – the insurer, principal and beneficiary/claimant, claims brought under surety bonds are not necessarily more complicated than claims brought under other types of insurance. Under current law (subsection 2695.7(b)) the 40 day time period within which an insurer must accept or deny a claim applies to both first and third party claims. Further, the written explanation required by this subsection is similar to requirements in subsection 2695.7(b) (1), which applies to all other types of insurance that are subject to these regulations. These minimum standards should also apply to surety claims.

Section 2695.10(b) (1) **Adopt**
This subsection is adopted to clarify that a principal's absence, failure to cooperate with the surety or meet his or her bonded obligation shall not excuse unreasonable delay by the surety in determining whether the claim should be accepted or denied. This requirement complements existing law which requires a surety to perform a diligent investigation, process claims in a timely manner and comply with the Unfair Claims Practices Act and regulations(California Insurance Code Section 790.03(h)(3)).

Section 2695.10(b) (2) **Adopt**
This subsection is adopted to clarify that no insurer shall deny a claim based solely upon a principal's protest or denial of liability but must conduct a thorough investigation of the claim as required by existing law (California Insurance Code Section 790.03(h)(3)).

Section 2695.10(g) **Adopt**
This subsection is adopted to mirror the general requirement under subsection 2695.7(f) that an insurer is to provide written notice of any statute of limitations no less than 60 days prior to the expiration date. This notification gives the claimant adequate time to file a lawsuit in the event his or her claim cannot be settled prior to the running of the applicable statute of limitations.

Section 2695.10(h) **Adopt**
This subsection is adopted to ensure that a surety shall not offer or attempt to offer unreasonably low settlements and specifies criteria to be used by the Commissioner in determining whether a settlement offer is unreasonably low. This language mirrors subsection 2695.7(g). Existing law

requires a surety to offer a fair settlement, perform a diligent investigation and process claims in a timely manner (California Insurance Code Section IC 790.03(h) (3) & (5)). This subsection complements existing law and clarifies the surety's responsibility without unreasonably increasing its duties.

SECTION 2695.11 Additional Standards Applicable to Life and Disability Insurance Claims

Section 2695.11(a)(1) **Amend**
The word "such" is removed for grammatical reasons.

Section 2695.12. Penalties.
Section 2695.12(a) **Amend**
This subsection has been amended to reflect that the factors described in this subsection go to the appropriate penalties to be assessed and not to whether an insurer was in noncompliance with any of the sections of the regulations. If an act is not in compliance with the regulations, it is necessarily in violation of the regulations regardless of mitigating factors. The mitigating factors to go how much penalty should be assessed.

Section 2695.12(a)(2) **Amend** (Re-letter)
The word "California" is added before the words "Insurance Code" for clarification purposes.

Section 2695.12(a)(7) **Amend** (Re-letter)
This subsection has been amended because, in order to determine the appropriate penalties to be assessed, the Department must consider the number of claims where violations have been found as compared to the number of claims examined by the Department. The current ratio using the number of claims handled by the insurer is not relevant in determining appropriate penalties as the Department does not examine all claims handled by insurers and would have no way of knowing whether violations would be found in those claim files not reviewed.

Section 2695.12(b) **Adopt**
This subsection is adopted to clarify that the provisions of Section 2695.12 do not alter the insurer's right to an administrative hearing under the Unfair Practices Act (Insurance Code Sections 790.05 et seq.) The language resolves any concerns by the insurance industry that these regulations circumvent an insurer's due process rights.

Section 2695.13. (NO CHANGES)

Section 2695.14 Compliance Date **(Adopt)**

Section 2695.14(a) **(Adopt)**
This subsection is adopted to clarify that licensees have 90 days from the date the amended regulations are filed with the Secretary of State to comply with the requirements of the amended regulations.

Section 2695.14(b) **(Adopt)**

This subsection is adopted to specify that, during the 90 day period specified in subsection 2695.14(a), licensees shall adopt standards that reflect the amended regulations and train their staff and claims agents on the amendments.

Section 2695.14(c) **(Adopt)**
This subsection is adopted to clarify that the date a claim occurred or is reported to the insurer does not dictate whether the amended regulations apply. Rather, the regulations shall apply to any claims handling occurring after the compliance date even if the claim occurred prior to the compliance date.

IDENTIFICATION OF STUDIES
There are no specific studies relied upon in the adoption of this subchapter.

SPECIFIC TECHNOLOGIES OR EQUIPMENT
Adoption of these regulations would not mandate the use of specific technologies or equipment.

ALTERNATIVES
The Commissioner has determined that no reasonable alternative exists to carry out the purpose for which the regulations are proposed. Performance standards were considered but were rejected as an unreasonable and impracticable alternative in the context of regulations that seek efficiently to define specific procedures that constitute fair business practices in the settlement of insurance claims.

ECONOMIC IMPACT ON SMALL BUSINESS
The Commissioner has identified no reasonable alternatives to the presently proposed regulations, nor have any such alternatives otherwise been identified and brought to the attention of the Department, that would lessen any impact on small business. Although performance standards were considered as an alternative, they were rejected, in part, because they would increase, rather than lessen, the impact upon small business. Unlike the proposed regulations, performance standards would not provide small businesses an efficient means of knowing how to comply, or of ensuring they have achieved compliance. Further, it could be necessary that small businesses incur the additional expense of legal fees charged by lawyers whose services might be required in order to interpret a performance standard. Finally, because of this indefiniteness, performance standards would be likely to breed costly litigation, which small businesses in particular can ill afford.

PRE-NOTICE DISCUSSIONS
Pursuant to Government Code Section 11346.45(a), public discussions were held on June 2, 2005 regarding proposed amendments to these regulations. Interested and affected parties were given an opportunity to present statements or comments with respect to the proposed amendments. The Commissioner considered these statements and comments and some changes were made to the proposed amendments in response.